APPLICATION FOR SOUTH DAKOTA RISK POOL HEALTH COVERAGE

Eligibility – To be considered an eligible individual, you must satisfy **all** of the following criteria:

- ♦ You must have had 12 months of continuous creditable coverage. Continuous coverage means you have not had a break in coverage of 63 or more days. Types of continuous coverage includes:
 - An employer-based health plan
 - An individual health plan
 - Medicare or Medicaid
 - Chapter 55 of Title 10, United States Code (Champus)
 - Indian Health Services or a tribal organization
 - A state health benefits risk pool
 - Chapter 89 of Title 5, United States Code (FEP)
 - A public health plan
 - A church plan
 - A college plan that is not a limited benefit plan

Note: Some limited benefit plans and dread disease plans are not creditable coverage. Short-term major medical and some policies that provide less than comprehensive major medical coverage apply toward the 12 months of creditable coverage requirement, but cannot be the coverage immediately prior to the effective date of the Risk Pool policy if the coverage was an individual plan. You should ask the assistance of your agent or contact the Risk Pool for further information as to whether you may qualify if you have one of these types of plans.

- ♦ You must apply within 63 days of losing your prior coverage.
- ◆ You must have **used up any COBRA or state continuation coverage** for which you were eligible.
- ◆ You are **not covered** under a group health plan, Medicare, Medicaid, or any other form of health insurance.
 - **Note:** If you are eligible or may be eligible for other health insurance you may want to apply or contact the Risk Pool for further information.
- ♦ Your most recent coverage was **not** terminated for nonpayment of premium or fraud.
- ♦ You must be a resident of this state. Examples of proof of residency include your driver's license, state issued ID card, and voter registration.

Name of Insurance Carrier or Program: Coverage or program effective date: Coverage or program termination date: Name of Coverde Individuals: Why did or why will your coverage terminate? HMO coverage is no longer available because you moved from the service area Yes No Insurance carrier is no longer renewing coverage in South Dakota Yes No Insurance carrier is no trenewing employer group coverage because group no longer meets eligibility requirements Yes No Employer is no longer providing group insurance Yes No COBRA or South Dakota Continuation expired Yes No No longer eligible for employer group coverage and COBRA or S.D. continuation coverage not available Yes No No longer eligible for Medicaid Yes No Membership Information Name (First, Middle, Last Date of Birth Social Security Number Home Phone Sex (M or F) Mailing Address City State Zip Physical Address (If different from mailing address) City State Zip Enrollment Application ote: Changes to your deductible may only be made to take effective at the beginning of the plan year (July 1). You may not crease deductible amounts after your initial selection. Coverage is not effective until notice is received from the Plan diministrator and the actual effective date may vary from the requested effective date. Jan A - \$1,000 deductible and B - \$3,000 deductible and	Coverage or program effective date: Coverage or program termination date: Name of Covered Individuals: Why did or why will your coverage terminate? • HMO coverage is no longer available because you moved from the service area Yes No • Insurance carrier is not renewing employer group coverage because group no longer meets eligibility requirements Yes No • Employer is no longer providing group insurance Yes No • COBRA or South Dakota Continuation expired Yes No • No longer eligible for employer group coverage and COBRA or S.D. continuation coverage not available Yes No • No longer eligible for Medicaid Yes No • No longer eligible for Medicaid Yes No • Membership Information Name (First, Middle, Last Date of Birth Social Security Number Home Phone Sex (M or F) Mailing Address City State Zip Physical Address (If different from mailing address) City State Zip C. Enrollment Application City State Zip C. Enrollment Application Coverage is not effective until notice is received from the Plan diministrator and the actual effective date may vary from the requested effective date. Plan A - \$1,000 deductible City State City C	I have involuntarily lost creditable coverage (as listed above)					□ No
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	months immediately preceding the date of this application.	. Tobacco Non-User Decl	aration				
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If you answered "No" to the above question, you may be eligible for a special tobacco non-user rate. You may be required to recertify your non-user status in the future. If it is determined that the tobacco-use status is misrepresented or inaccurate during the initial two years, the difference in premium will be retroactively collected from the date you first received the non-user rate. If determination is made beyond the two-year

period, your premiums will increase to the tobacco-user rate on the first of the month following the determination. If you resume smoking or using tobacco products, you must notify the Risk Pool administrator.

E. Other Insurance (Attach separate sheet if additional space is needed.)

Health benefits can be provided by other insurance policies, coverage or programs that pay benefits when a certain diagnosis is made, a certain dollar threshold has been met, a certain procedure is performed, or certain charges are incurred. Examples include cancer policies, hospital indemnity policies, supplemental insurance (AFLAC type policies) and others.

• I currently have other types of coverage.	□ Yes □ No
Name of insurance carrier or program	
Type of coverage:	
Coverage or program effective date:	
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Name of insurance carrier or program.	
Type of coverage:	
Coverage or program effective date:	
Coverage or program termination date	:
Name of insurance carrier or program	
Coverage or program effective date:	
Coverage or program termination date	:
coverage for myself in this application. I also above is correct, and having read this form an represent that they are true and complete to the application (and any other required parts) share statements or misrepresentation, or have failed provided under this application may be considured under that I must pay the appropriate presentation and a signed ACH form and premium for and a plan is not provided, the only obligation. I authorize any health care provider to release reasonably related to the coverage for which I	application. I certify that I am legally authorized to apply for hereby agree that (1) I represent that all information shown d the above statements and answers and any attachments, I e best of my knowledge and belief, and agree that this II be the basis for any plan provided; (2) If I made any false d to disclose or have concealed any material fact, coverage lered void and the allowance of benefits will be refused; and (3) emium amount in advance to maintain coverage and have rethe first two months of coverage. If this application is declined to the Risk Pool will be to return any premium paid. I medical records to the Risk Pool or its designee when thave applied. If any law or regulation requires additional
release records pertinent to prior health or me	will give this authorization. I authorize any insurance carrier to dical coverage provided under that plan, including limited furnish all information required to administer this coverage.
Applicant's Signature	Date/
For agent use only (If applicable):	
Printed Name	Agent Signature
☐ Pay agent license #	☐ Pay agency FEIN#
Payee name & mailing address	
Agent Phone #	Agent Fax #